SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED- ADULT INTENSIVE RESILIENCY SERVICES (AIRS)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit). The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Adult Intensive Rehabilitative Services (AIRS) is a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS may be provided for consumers at least eighteen (18) years of age with serious mental illness who need structured therapeutic and rehabilitative services; Have significant impairment in day-to-day personal, social and/or vocational functioning; do not require acute stabilization, including inpatient or detoxification services, and Are not at imminent risk of harm to self or others. AIRS may be provided to consumers less than eighteen (18) years of age, but not less than sixteen (16) years of age, with an approved prior authorization.

II. Service Delivery

- AIRS must be authorized by a physician or HSPP.
- Direct services must be supervised by a licensed professional.
- Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
- Consumer goals must be designed to facilitate community integration, employment, and use of natural supports.
- Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
- A weekly review and update of progress occurs and must be documented in the consumer's clinical record.

- AIRS programs must be offered a minimum of two (2) hours and up to six (6) hours per day, three (3) to five (5) days per week, excluding time associated with formal educational or vocational services.
- AIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under.
- The consumer is the focus of the service.
- Documentation must support how the service benefits the consumer, including when provided in a group setting.
- Services must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
- Service goals must be rehabilitative in nature.

Exclusions:

- AIRS will not be reimbursed for consumers who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW U1) on the same day.
- Services that are purely recreational or diversionary in nature, or that do not have therapeutic or programmatic content, are not reimbursable.
- Formal educational or vocational services.
- A consumer may not receive both CAIRS and AIRS on the same day.

III. Target Population

- Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.

In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcomes

Goal #1
Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

1) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of each month following the month of service.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objectives

1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

Client Outcome Measures:

1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Qualifications

Services are provided through a behavioral health service provider that is enrolled as a Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate.
Individual Provider Qualifications:

- Licensed professional
- Qualified Behavioral Health Professional
- Other Behavioral Health Professional

VI. Billable Unit

Medicaid:

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding, except for court time and time spent attending the CFTM which can be billed to DCS. Medicaid shall be billed when appropriate.

Billing Code	Title
H2012 HW HB U1	Behavioral health day treatment, per hour

Units = 1hour, provider must provide ≥ 45 minutes of service to round up.

DCS Funds:

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **CFTM:** Child and Family Team Meeting: The provider of this service may be requested to participate in the CFTM. The provider may bill DCS per hour for this actual time spent in CFTM.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children

3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-ASSESSMENT FOR MRO

I Services Description

This service standard applies to services provided to children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Clinic Option (MCO), Medicaid Rehabilitation Option (MRO), and DCS Funding. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MCO or MRO may be billed to DCS. The DCS service model shall be used for this service standard.

This service standard includes the Initial Assessment-Clinic, Initial Assessment-Home, and Redetermination. A client should only receive a referral for one of these assessments at any given time.

Initial Assessment:

The purpose of this initial assessment is to have the following completed and summarized in a report:

- DMHA approved assessment
- Bio-psychosocial assessment and
- Diagnosis (if applicable).
- Summary of CMHC Recommended Services

DCS will refer for an Initial Assessment-Clinic to be completed and billed to Medicaid Clinic Option (MCO). This assessment should be completed with a report to DCS within 7 calendar days unless the services will require prior authorization (the child is not eligible for a preauthorized service package). If a prior authorization for services is required, the assessment should be completed and a report returned to DCS within 17 days.

If the family is not responsive within 3 days, the CMHC should contact the FCM to determine if the FCM wants to request the Initial Assessment to be completed in the home. If so, the FCM should complete a new referral for Initial Assessment-Home. In this instance, the Assessment time period of 7 calendar days would start over. (NOTE: The time period on the referral will be for 6 months and will be used to authorize DCS match payment electronically for that time period.)

If, at the time the FCM makes the initial referral, the FCM believes there are circumstances which would prevent the family from going to the clinic, DCS may choose to refer for an Initial Assessment-Home to be completed in the family's home. The Initial Assessment-Home unit would be paid by DCS funding.

Behavioral Health level of Need Redetermination

Redetermination Services are associated with the DMHA approved assessment required to determine level of need, assign an MRO service package and make changes to the Individualized Integrated Care Plan. The DMHA assessment tool must be completed at least every six (6) months for the purpose of determining the continued need for MRO services. Reassessment may occur when there is a significant event or change in consumer status.

II. Service Delivery

Initial Assessment:

1. Face-to face contact in a MCO approved setting is preferred.
2. CMHC will respond with a report in 7 calendar days from date of referral approval. If Prior Authorization is required, the CMHC will notify DCS and will respond with a report in 17 days.
3. The report will include the DMHA approved assessment, a Bio-psychosocial assessment, the child's diagnosis (if applicable), and the MRO Service Package or authorized services.

Redetermination

1. The redetermination requires face-to-face contact with the consumer and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.
2. The DMHA approved assessment tool must be completed at least every six months to determine the continued need for MRO services
3. Reassessment may occur when there is a significant event or change in consumer status. Reimbursement is only available for one assessment per six months. .
4. CMHC will inform the referring worker of the need for a redetermination referral at least 14 days prior to the need for the approved referral.

III. Target Population

Assessments and Redeterminations are billable to Medicaid for Medicaid eligible clients. In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcomes

Goal #1 To obtain an Initial Assessment that will result in the identification of the MRO service package if applicable.

Objective Measure: 95% of Initial Assessments will be completed within the designated time frames.

V. Qualifications

Initial Assessment:

Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except
that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in
psychiatric or mental health nursing from an accredited school of nursing.

Redetermination:

Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.

VI. Billable Unit

Initial Assessment-MCO Clinic:
Initial Assessment-Clinic will be billed **per assessment** to clinic option for Medicaid eligible clients. Medicaid shall be billed when appropriate.

Medicaid Billing Code	Description
90801	Diagnostic Interview

Initial Assessment-Clinic (DCS Paid):

- Initial Assessment-**Clinic** will be paid **per assessment** by DCS for those clients who are not Medicaid eligible.

Initial Assessment-Home (DCS Paid):

- Initial Assessment-Home will be paid **per assessment** by DCS.

Behavioral Health Level of Need Redetermination:

Services through the Medicaid Rehabilitation Option (MRO) include Behavioral Health level of Need Redetermination. Medicaid shall be billed when appropriate. DCS funds should not be billed for this service.

Medicaid Billing Code	Description
H0031 HW	Mental health assessment, by non physician

VII. Case Record Documentation

Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10thof each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

NOTE: All services must be pre-approved through a referral form from the referring FCM or Probation Officer.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED- CHILD AND ADOLESCENT INTENSIVE RESILIENCY SERVICES (CAIRS)

I. Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit) The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Child and Adolescent Intensive Resiliency Services (CAIRS) is a time-limited, curriculum-based, non-residential service provided to children and adolescents in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS is designed to alleviate emotional or behavioral problems with a goal of reintegration into age appropriate community settings (e.g., school and activities with pro-social peers). CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS may be provided for consumers at least five (5) years of age and less than eighteen (18) years of age with severe emotional disturbance who: Need structured therapeutic and rehabilitative services; Have significant impairment in day-to-day personal, social and/or vocational functioning; Do not require acute stabilization, including inpatient or detoxification services; and Are not at imminent risk of harm to self or others.

II. Service Delivery

a. CAIRS must be authorized by a physician or HSPP.
b. Direct services must be supervised by a licensed professional.
c. CAIRS must be provided in close coordination with the educational program provided by the local school district.
d. Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
e. Consumer goals and a transitional plan must be designed to reintegrate the consumer into the school setting.
f. Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.

g. A weekly review and update of progress occurs and must be documented in the consumer's clinical record.
h. CAIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under receiving services.
i. CAIRS programs must be offered a minimum of two (2) hours and a maximum of four (4) hours per day, three (3) to five (5) days per week, excluding time associated with formal educational or vocational services.
j. CAIRS must be provided in an age appropriate setting for a consumer age eighteen (18) and under.
k. The consumer is the focus of the service.
l. Documentation must support how the service benefits the consumer, including when provided in a group setting.
m. CAIRS must demonstrate movement toward or achievement of consumer treatment goals identified in the individualized integrated care plan.
n. CAIRS goals must be rehabilitative in nature.

Exclusions:

i. Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content are not reimbursable.
ii. Formal educational or vocational services.
iii. CAIRS is not reimbursable for children less than five (5) years of age.
iv. CAIRS is not reimbursable for consumers age eighteen (18) and older, but less than twenty-one (21) years of age without an approved prior authorization.
v. CAIRS will not be reimbursed for consumers who receive Individual or Group Skills Training and Development (H2014 HW or H2014 HW UI) on the same day.
vi. A consumer may not receive both CAIRS and AIRS on the same day.

III. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need, and must meet the MRO target population definition as listed above.

In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcomes

Goal #1
Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

1) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of each month following the month of service.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objectives

1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

Client Outcome Measures:

1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.

2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Qualifications

Services are provided through a behavioral health service provider that is an enrolled as a Medicaid provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate. CAIRS may be provided in a facility provided by the school district.

Individual Provider Qualifications:

- Licensed professional
- Qualified Behavioral Health Professional
- Other Behavioral Health Professional

VI. Billable Unit

Medicaid:

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding, except for court time and time spent attending the CFTM which can be billed to DCS. Medicaid shall be billed when appropriate.

Billing Code	Title
H2012 HW HA U1	Behavioral health day treatment, per hour

Units = 1hour, provider must provide ≥ 45 minutes of service to round up.

DCS Funds:

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **CFTM:** Child and Family Team Meeting: The provider of this service may be requested to participate in the CFTM. The provider may bill DCS per hour for this actual time spent in CFTM.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-COUNSELING

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO), Medicaid Clinic Option (MCO) and DCS Funding. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the Medicaid eligible client. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO or MCO may be billed to DCS. The DCS service model shall be used for this service standard.

Provision of structured, goal-oriented therapy on the issues related to the referral for family members who need assistance recovering from physical abuse, sexual abuse, emotional abuse, or neglect. Other issues, including substance abuse, dysfunctional families of origin, etc., may be addressed in the course of treating the abuse or neglect.

Professional staff provides individual, group, and/or family counseling with emphasis on one or more of the following areas:

- Conflict resolution
- Behaviors modification
- Identify systems of support
- Interpersonal relationships
- Communication skills
- Substance abuse awareness
- Parenting skills
- Anger management
- Supervised therapeutic visits
- Problem solving
- Stress management
- Goal-setting
- Domestic violence issues
- School problems
- Family of origin/inter-generational issues
- Sexual abuse – victims and caretakers of sexual abusers

II. Service Delivery

1) Services are provided at a specified (regularly scheduled) time for a limited period of time.
2) For DCS, services are provided face-to-face in the counselor's office or other setting. For MCO, the service setting is either outpatient or office setting. For MRO, the

service must be provided at the client's home or other at other locations outside the clinic setting.
3) Services will be based on objectives derived from the family's established DCS/Probation case plan, Informal Adjustment, taking into consideration the recommendations of the Child and Family Team (CFT) and authorized by DCS/Probation referral, and subsequent written documents.
4) The counselor will be involved in Child and Family Team Meetings (CFTM) if invited.
5) Counselor must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
6) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued, culturally competent manner.
7) Services include providing any requested testimony and/or court appearances, including hearings and/or appeals.
8) Services must be provided at a time convenient for the family.
9) Services will be time-limited.
10) Written reports will be submitted monthly to provide updates on progress and recommendation for continuation or discontinuation of treatment.

III. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. Services billable to MCO are for Medicaid eligible clients. In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
2) Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcome Measures

Goal #1

Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

1) DCS/Probation worker may assist provider in contacting the family and beginning the engagement process.
2) Therapist or backup is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer within 30 days of the receipt of the referral.
3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objectives

1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

Client Outcome Measures:

1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Qualifications

Counselor/Direct Worker:

MCO:

- Medical doctor, doctor of osteopath; licensed psychologist
- Physician or HSPP-directed services provided by the following: licensed clinical social worker, licensed marital and family therapist; licensed mental health counselor; a person holding a master's degree in social work, marital and family therapy or mental health counseling; an advanced practice nurse.

MRO:

- Providers must meet the either of the following qualifications: Licensed professional, except for a licensed clinical addiction counselor or a qualified behavioral health professional (QBHP).

Supervision

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development,
- Knowledge of community resources and ability to work as a team member;
- Beliefs in helping clients change their circumstances, not just adapt to them,
- Belief in adoption as a viable means to build families.

- Understanding regarding issues that are specific and unique to adoptions, such as loss, mismatched expectations and flexibility, entitlement, gratification delaying, flexible parental roles, and humor.

Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VI. Billable Units

Medicaid:
It is expected that the majority of the individual, family and group counseling provided under this standard will be based in the clinic setting. Some group counseling may occur in the community. In these instances, the units may be billable through MRO. Medicaid shall be billed when appropriate.

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

Services through the Medicaid Rehab Option **(MRO)** may be **group** Behavioral Health Counseling and Therapy**.**

Billing Code	**Title**
H0004 HW U1	Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)
H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present

DCS funding:

Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face

hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible.

- **Face-to-face time with the client**
  (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family.)

  - Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
  - Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
  - Includes Child and Family Team Meetings or case conferences including those via telephone initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family

  Reminder: *Not included are routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face- to-face rate and shall not be billed separately.*

- **Group Counseling**
  Services include group goal directed work with clients. To be billed per client per group meeting.

  Hourly services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• *0 to 7 minutes*	*do not bill*	*0.00 hour*
• *8 to 22 minutes*	*1 fifteen minute unit*	*0.25 hour*
• *23 to 37 minutes*	*2 fifteen minute units*	*0.50 hour*
• *38 to 52 minutes*	*3 fifteen minute units*	*0.75 hour*
• *53 to 60 minutes*	*4 fifteen minute units*	*1.00 hour*

- **Court**
  The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost

associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **Translation or sign language**
  Services include translation for families who are non-English language speakers or hearing- impaired and must be provided by a non-family member of the client. Dollar-for-dollar amount.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

1) A completed, dated, signed DCS/Probation referral form authorizing service;
2) Documentation of regular contact with the referred families/children and referring agency;
3) Written reports no less than monthly or more frequently as prescribed by DCS. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-DIAGNOSTIC AND EVALUATION SERVICES

I. Services Description

Diagnostic and assessment services will be provided as requested by the referring worker for parents, other family members, and children due to the intervention of the Department of Child Services because of alleged physical, sexual, or emotional abuse or neglect, the removal of children from the care and control of their parents, and/or children alleged to be a delinquent child or adjudicated a delinquent child. When either a psychological or emotional problem is suspected to be contributing to the behavior of an adult or child or interfering with a parent's ability to parent, they should be referred for an initial bio-psychosocial assessment by a direct worker. If a psychiatric consultation/medication evaluation or either psychological or neuropsychological testing is necessary to answer a specific question, testing may be included in the evaluation after a consultation with the Family Case Manager (FCM) about the purpose of testing. Specific tests may include instruments that assess ability and achievement, substance use/abuse, testing for personality and psychopathology, and assessments of adaptive living skills. The results of the evaluation including diagnostic impression and treatment recommendations will be forwarded to the Family Case Manager to assist the family in remedying the problems that brought the family to the attention of child protective services or probation.

II. Service Delivery

Clinical Interview and Assessment

The purpose of the Clinical Interview and Assessment is to have the following completed and summarized in a report:

- Bio-psychosocial assessment
- Parenting Functioning assessment
- Diagnosis (if applicable)
- Summary of Recommended Services and Service Approach

1. The completed report will utilize the DCS standardized report format for Diagnostic Evaluation Services. The report should be completed with a summary to DCS within 15 calendar days of referral.
2. The service provider may recommend psychological testing, neuropsychological testing and/or psychiatric consultation/medication evaluation as a result of the bio-psychosocial assessment. If psychological testing or neuropsychological testing is recommended, the service provider should include in the report the specific issues/questions the testing should

address. A new referral under this service standard will be required for these services.

3. The service provider may recommend a Parenting/Family Functioning Assessment. Justification as to why this level of assessment is necessary should be included in the report. A new referral Parenting/Family Functioning Assessment will be required for this service.

Psychological Testing

1. The psychologist will conduct applicable psychological testing as recommended during the Clinical Interview and Assessment and approved by the Family Case Manager.
2. The psychologist will respond with a written report within 30 days from the date of the referral.

Neuropsychological Testing

1. The psychologist will conduct applicable neuropsychological testing as recommended by the service provider and approved by the Family Case Manager.
2. The psychologist will respond with a written report within 45 days from the date of the referral.

Medication Evaluation

If psychiatric consultation/medication evaluation is recommended, the psychiatrist will see the client within 14 days from the date of referral and complete a written report within 30 days from the date of evaluation.

Ongoing Medication Monitoring

Ongoing medication monitoring will be provided as needed based on the results of the Medicaid Evaluation.

Child Hearsay Evaluation

An evaluation completed by a psychiatrist, physician, or psychologist to determine if participation in court proceedings would create a substantial likelihood of emotional or mental harm to the child. A completed report will be provided to the referring worker with in 14 days of referral.

III. Target Population

Services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.

2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families

IV. Goals and Outcomes

Goal #1
Timely receipt of evaluations.
Objective:
1) Service provider to submit written report to the referring Family Case Manager within the designated time frames of completion of evaluation.

Outcome Measure/Fidelity Measure

1) 95% of the evaluation reports will be submitted to the referring Family Case Manager within specified service delivery time frames.

Goal #2
Obtain appropriate recommendations based on information provided.
Outcome Measure
1) 100% of reports will meet information requested by the referring Family Case Manager/Probation Officer.
2) 100% of reports will include recommendations for treatment, needed services or indicate no further need for services.

Goal #3
Client satisfaction with service provided.
Outcome Measure

1) DCS and/or probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) A random Sample of Satisfaction Surveys will be completed at the conclusion of services.

V. Minimum Qualifications

Clinical Interview and Assessment Reimbursed by DCS:
Diagnosis and assessment may only be done independently by a Health Services Provider in Psychology (HSPP). The following providers may provide bio-psychosocial assessments under the direct supervision of a Health Service Provider in Psychology (HSPP) psychologist or psychiatrist.

- Master's degree in social work, psychology, marriage and family therapy, or related human services field.

- Masters degree with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist or Mental Health Counselor Board, as one of the following: 1) Clinical Social Worker 2) Marriage and Family Therapist 3) Mental Health Counselor.

Clinical Interview and Assessment Reimbursed by Medicaid:

Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when such services are provided by one (1) of the following practitioners:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A licensed clinical social worker.
(D) A licensed marital and family therapist.
(E) A licensed mental health counselor.
(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling
(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:

(A) The physician, psychiatrist, or HSPP is responsible for seeing the recipient during the intake process or reviewing the medical information obtained by the practitioner listed above within seven (7) days of the intake process. This review by the physician, psychiatrist, or HSPP must be documented in writing.
(B) The physician, psychiatrist, or HSPP must again see the patient or review the medical information and certify medical necessity on the basis of medical information provided by the practitioner listed above at intervals not to exceed ninety (90) days. This review must be documented in writing.

Psychological & Neuropsychological Testing Reimbursed by DCS:

Test Interpretation
Diagnosis and assessment may only be done independently by a Health Services Provider in Psychology (HSPP) or physician.

Test Administration
The following practitioners may **administer** psychological testing under the direct supervision of a HSPP or physician:

(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a bachelor's degree and one (1) of the following:
(i) twenty (20) hours of documented specific instruction and direct supervision by a physician or HSPP psychologist at the performance site on the tests to be used including instruction on administration and scoring and practice assessments with non-patients and final approval to administer the specific instruments by a physician or HSPP psychologist at the performance site; or
(ii) status as a psychology intern enrolled in an American Psychological Association (APA)-approved internship program.
(D) A psychology resident enrolled in an APA-approved training program or APPIC recognized internship or post-doctoral program.
(E) An individual certified by a national organization in the administration and
scoring of psychological tests.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one of the lower level practitioners.

Psychological & Neuropsychological Testing reimbursed by Medicaid:

Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when provided by a physician or an HSPP. The services are provided by one (1) of the following practitioners:
(A) A physician.
(B) An HSPP.
(C) The following practitioners may only **administer** neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
1. A licensed psychologist.
2. A licensed independent practice school psychologist.
3. A person holding a master's degree in a mental health field and one (1) of the following:
(a) A certified specialist in psychometry (CSP).

(b) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

The physician and HSPP are responsible for the interpretation and reporting of the testing performed. The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one of the practitioners listed in subdivision (C).

Medication Evaluation and Ongoing Medication Management:
(A) Physician
(B) Advanced Practice Nurses (Nurse Practitioners or Certified Nurse Specialists) with a 1) master or doctoral degree in nursing with a major in psychiatric or mental health nursing, 2) from an accredited school of nursing.

If working as an Authorized Health Professional staff must 1) be an Advance Practice Nurse as described above, 2)and prescriptive authority, 3)must work within the scope of his/her license and 4) have a supervisory agreement with a licensed physician.

VI. Billable Unit

Medicaid:
It is expected that the diagnostic and assessment services provided under this standard will be based in the clinic setting. Medicaid shall be billed when appropriate. Services will be billable by utilizing the 90000 codes.

DCS Funding:
Those services not billable under Medicaid, may be billed to DCS as follows:

All of the following may be billed under the DCS MED-Diagnostic Evaluation Service Code.

Will be billed at the D & E rate.

- **Clinical Interview and Assessment:** Hourly Rate-Face to Face time with a client. Plus a maximum of 1 hour may be billed for report writing.

- **Psychological Testing**: Per Hour. Includes time face to face with the client and time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for report writing.

- **Neuropsychological Testing:** Per Hour. Includes time face to face with the client and time spent administering, scoring, and interpreting testing. Plus a maximum of 1 hour may be billed for report writing.

- **Child Hearsay Evaluation**: per hour face to face with the client. Plus a maximum of ½ hour may be billed for report writing.

Will be billed at the Psychiatric rate:

- **Medication Evaluation**: per hour face to face with the client. Plus a maximum of ½ hour may be billed for report writing.

- **Ongoing Medication Monitoring**: per hour face to face with the client.

Hourly Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

○ 0 to 7 minutes	do not bill	0.00 hour
○ 8 to 22 minutes	1 fifteen minute unit	0.25 hour
○ 23 to 37 minutes	2 fifteen minute units	0.50 hour
○ 38 to 52 minutes	3 fifteen minute units	0.75 hour
○ 53 to 60 minutes	4 fifteen minute units	1.00 hour

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **Translation or sign language:**
  Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

1) A completed, dated, signed DCS/Probation referral form authorizing service;
2) Written reports as defined in this service standard.
3) Documentation regarding efforts to secure low cost or free medications prior to billing DCS.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED - HOME-BASED FAMILY CENTERED CASEWORK SERVICES

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO), and DCS Funding. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS. The DCS service model shall be used for this service standard.

Provision of home-based casework services for families involved with DCS/Probation. Home-based casework is also available for pre-adoption and post-adoption services for adoptive families at risk or in crisis. Home-based Caseworker Services (HCS) provides any combination of the following kinds of services to the families once approved by DCS/Probation:

- Home visits
- Participation in DCS Case planning
- Supervised visitation
- Coordination of services
- Conflict management
- Emergency/crisis services
- Child development education
- Domestic violence education
- Parenting education/training
- Family communication
- Facilitate transportation*
- Participation in Child and Family Team meetings
- Family reunification/preservation
- Foster family support
- Advocacy
- Family assessment
- Community referrals and follow-up
- Develop structure/time management
- Behavior modification
- Budgeting/money management
- Meal planning/preparation
- Parent training with children present
- Monitor progress of parenting skills
- Community services information
- Develop long and short-term goals

* HCS transport limited to client goal-directed, face-to-face as approved/specified as part of the case plan or goals/objectives identified at the Child and Family Team Meeting. (e.g. housing/apartment search, etc.)

II. Service Delivery

1) Service provision must occur with face-to-face contact with the family within 48 hours of referral.
2) Services must include 24 hour crisis intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
3) Services must include ongoing risk assessment and monitoring family/parental progress.
4) The family will be the focus of service, and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
5) Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
6) Services must include development of short and long-term family goals with measurable outcomes that are consistent with the DCS case plan.
7) Services must be family focused and child centered.
8) Services may include intensive in-home skill building and must include after-care linkage.
9) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing. Monthly reports are due by the 10thof each month following the month of service.
10) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
11) Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
12) The caseload of the HCS will include no more than 12 active families at any one time.
13) Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited. A treatment plan will be developed based on assessment by the provider and agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.
14) Each family receives comprehensive services through a single HCS acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.

III. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcome Measures

Goal #1

Maintain timely intervention with the family and regular and timely communication with referring worker.

Objectives

1) DCS/Probation worker may assist provider in contacting the family and beginning the engagement process.
2) HCS or back-up is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current Family Case Manager/Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer following receipt of the referral within 30 days of contact with the client.
3) 95% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer by the 10th of the month following the services. .

Goal #2

Clients will achieve improved family functioning.

Objectives:

1) Goal setting, and service planning are mutually established with the client and HCS within 30 days of the initial face-to-face intake and a written report signed by the HCS and the client is submitted to the current FCM/ Probation Officer.

Client Outcome Measures:

1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period
2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period

Goal #3

DCS/ Probation and clients will report satisfaction with services.

Outcome Measures:

1) DCS/ Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Qualifications

Direct Worker:
Bachelor's degree in social work, psychology, sociology, or a directly related human service field.

Supervisor:
Master's degree in social work, psychology, or directly related human services field.

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

- Knowledge of child abuse and neglect, and child and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adapt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VI. Billable Units

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Case Management and/or Skills Training & Development. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care Skills Training and Development services for the MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

- Medically necessary behavioral health care Case Management for the MRO child will be paid per 15 minute unit. Case Management services should not exceed those included in the MRO package.

Billing Code	Description
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)
H2014 HW HS	Skills Training and Development, per 15 minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15

	minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

DCS holds overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHC's may provide case management services with this specific focus.

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible.

- **Face-to-face time with the client** (Note: Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family.)

    - Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
    - Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
    - Includes Child and Family Team meetings or case conferences including those via telephone initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family.
    - Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).

    Reminder: *Not included are routine report writing and scheduling of appointments, collateral contacts, travel time, and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.*

    Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

    - *0 to 7 minutes do not bill 0.00 hour*
    - *8 to 22 minutes 1 fifteen minute unit 0.25 hour*

- *23 to 37 minutes* *2 fifteen minute units* *0.50 hour*
- *38 to 52 minutes* *3 fifteen minute units* *0.75 hour*
- *53 to 60 minutes* *4 fifteen minute units* *1.00 hour*

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **Translation or sign language:** Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar-for-dollar amount.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10thof each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging,

teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED-HOME-BASED FAMILY CENTERED THERAPY SERVICES

I. Service Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO), and DCS Funding. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral health care needs of the MRO eligible client. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO may be billed to DCS. The DCS service model shall be used for this service standard.

Provision of structured, goal-oriented, time-limited therapy in the natural environment of families who need assistance recovering from physical, sexual, emotional abuse, and neglect. Other issues, including substance abuse, mental illness, personality/behavior disorder, developmental disability, dysfunctional family of origin, and current family dysfunction, may be addressed in the course of treating the abuse/neglect.

Professional staff will provide family and/or individual therapy including one or more of the following areas:

- Family of origin/intergenerational issues
- Family organization (internal boundaries, relationships, roles)
- Stress management
- Self-esteem
- Communication skills
- Conflict resolution
- Behavior modification
- Parenting skills/Training
- Substance abuse
- Crisis intervention
- Strengths based perspective
- Adoption issues
- Participation in Child and Family Team meetings
- Sex abuse
- Goal setting
- Family structure (external boundaries, relationships, socio-cultural history)
- Problem solving
- Support systems
- Interpersonal relationships
- Therapeutic supervised visitation
- Family processes (adaptation, power authority, communications, META rules)
- Cognitive behavioral strategies
- Brief therapy
- Family reunification/preservation
- Grief and loss
- Domestic violence education

II. Service Delivery

1) Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home. Limited services may also be provided at a community site.
2) Services must include ongoing risk assessment and monitoring family/parental progress.
3) The family will be the focus of service and services will focus on the strengths of the family and build upon these strengths. Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation. This may include persons not legally defined as part of the family. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
5) Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation case plan or Informal Adjustment.
6) Services must include development of short and long-term family goals with measurable outcomes.
7) Services must be family focused and child centered.
8) Services may include intensive in-home skill building and must include after-care linkage.
9) Services include providing monthly progress reports; requested supportive documentation such as case notes, social summaries, etc.; and requested testimony and/or court appearances including hearings and/or appeals; case conferences/staffing.
10) Staff must respect confidentiality. Failure to maintain confidentiality may result in immediate termination of the service agreement.
11) Services will be conducted with behavior and language that demonstrates respect for socio- cultural values, personal goals, life style choices, and complex family interactions and be delivered in a neutral-valued culturally-competent manner.
12) The caseload of the Home-Based Family Centered Therapist (HBFCT) will include no more than 12 active families at any one time.
13) Services will be provided within the context of the DCS practice model or Probation plan with involvement in Child and Family Team (CFT) meetings if invited. A treatment plan will be developed based on agreements reached in the Child and Family Team meetings and/or documented in the authorizing referral.
14) Each family receives comprehensive services through a single HBFCT acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.

III. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
2) Children and their families which have an IA or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) Any child who has been adopted, and adoptive families.

IV. Goals and Outcome Measures

Goal #1

Maintain timely intervention with family and regular and timely communication with current Family Case Manager or Probation Officer.

Objectives

1) DCS/Probation worker may assist provider in contacting the family and beginning the engagement process.
2) HBFCT or backup is available for consultation to the family 24-7 by phone or in person.

Fidelity Measures:

1) 95% of all families that are referred will have face-to-face contact with the client within 5 days of receipt of the referral or inform the current Family Case Manager or Probation Officer if the client does not respond to requests to meet.
2) 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer within 30 days of the receipt of the referral.
3) 100% of all families will have monthly written summary reports prepared and sent to the current Family Case Manager/Probation Officer. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

Goal #2

Improved family functioning including development of positive means of managing crisis.

Objectives

1) Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.

Client Outcome Measures:

1) 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
2) 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period. (To be measured/evaluated by DCS/Probation staff)
3) 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.

Goal #3

DCS/Probation and clients will report satisfaction with services provided.

Outcome Measures:

1) DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 90% of the clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Qualifications

HBFCT/Direct Worker:

Providers must meet the either of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified Behavioral Health Professional (QBHP)

Supervisor:

Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision. The frequency and intensity of training and supervision are to be consistent with "best practices" and comply with the requirements of each provider's accreditation body. Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies. Under no circumstances is supervision/consultation to be less than one (1) hour of supervision/consultation per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

In addition to the above:

- Knowledge of child abuse/neglect and adult development
- Knowledge of community resources and ability to work as a team member
- Belief in helping clients change their circumstances, not just adopt to them
- Belief in adoption as a viable means to build families
- Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss pf familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles and humor

Services provided will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, life-style choices, as well as complex family interactions; services will be delivered in a neutral-valued culturally-competent manner.

VI. Billable Units

Medicaid: Services through the Medicaid Rehab Option (MRO) may be Behavioral Health Counseling and Therapy. Medicaid shall be billed when appropriate.

- Medically necessary behavioral health care services for MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.

Billing Code	Title
H0004 HW	Behavioral health counseling and

	therapy, per 15 minutes
H0004 HW HR	Behavioral health counseling and therapy, per 15 minutes (family/couple, with consumer present)
H0004 HW HS	Behavioral health counseling and therapy, per 15 minutes (family/couple, without consumer present

DCS Funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible.

- **Face-to-face time with the client** (Note: Members of the client family, which may include foster parents, are to be defined in consultation with the family and approved by the DCS/Probation. This may include persons not legally defined as part of the family.)

    - Includes client-specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
    - Includes crisis intervention and other goal-directed interventions via telephone with the identified client family.
    - Includes Child and Family Team meetings or case conferences including those via telephone initiated or approved by the DCS/Probation for the purposes of goal-directed communication regarding the services to be provided to the client/family.
    - Includes in-vehicle (or in-transport) time with client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).

Reminder: *Not included are routine report writing and scheduling of appointments, collateral contacts, travel time, and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.*

Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

○ *0 to 7 minutes*	*do not bill*	*0.00 hour*
○ *8 to 22 minutes*	*1 fifteen minute unit*	*0.25 hour*
○ *23 to 37 minutes*	*2 fifteen minute units*	*0.50 hour*
○ *38 to 52 minutes*	*3 fifteen minute units*	*0.75 hour*
○ *53 to 60 minutes*	*4 fifteen minute units*	*1.00 hour*

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

- **Translation or sign language:** Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar-for-dollar amount.

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

1) A completed, dated, signed DCS/Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS /Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by DCS/Probation. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED- MEDICATION TRAINING AND SUPPORT

I Services Description

This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation. Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit). The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements, and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The DCS service model shall be used for this service standard.

Individual:
Individual Medication Training and Support involves face-to-face contact with the consumer and/or family or non professional caregivers in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medication, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non face-to-face activities.

Group:
Medication Training and Support involves face-to-face contact with the consumer and/or family or non professional caregivers in a group setting, for the purpose of providing education and training about medications and medication side effects.

II Service Delivery

Individual:
1. Face-to face contact in an individual setting with the consumer and/or family or non professional caregivers that includes monitoring self-administration of prescribed medications and monitoring side effects.
2. When provided in a clinic setting, Medication Training and Support may support, but not duplicate, activities associated with medication management activities available under the Clinic Option. When provided in residential treatment setting, Medication Training and Support may include components of medication management services.
3. Medication Training and Support may also include the following services that are not required to be provided face-to-face with the consumer:

- Transcribing physician or AHCP medication orders.
- Setting or filling medication boxes.
- Consulting with the attending physician or Authorized Health Care Professional (AHCP) regarding medication – related issues.
- Ensuring linkage that lab and /or other prescribed clinical orders are sent.
- Ensuring that the consumer follows through and received lab work and services pursuant to other clinical orders.
- Follow up reporting of lab and clinical test results to consumer and physician.

4. The consumer is the focus of the service.
5. Documentation must support how the service benefits the consumer, including when the consumer is not present.
6. Medication Training and Support must demonstrate movement toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan.
7. Medication Training and Support goals are rehabilitative in nature.

Group:

1. Face-to-face contact in a group setting with the consumer and/or family or non professional caregivers that includes education and training on administration of prescribed medications and side effects, and/or conducting medication groups or classes.
2. When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
3. Medication Training and Support must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.
4. The consumer is the focus of the service.
5. Documentation must support how the service benefits the consumer, including when the consumer is not present.
6. Medication Training and Support must demonstrate movement toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan.
7. Medication Training and Support goals are rehabilitative in nature.

Exclusions:

1. If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider.

2. Coaching and instruction regarding consumer self-administration of medications is not reimbursable under Medication Training and Support, but may be billed as Skills Training and Development**.**
3. Medication Training and Support may not be provided for professional caregivers.

III **Target Population**

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

1) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
2) Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
3) Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
4) All adopted children and adoptive families.

IV. Goals and Outcomes

Goal #1 Maintain timely intervention with the family and regular and timely communication with referring worker.

Objectives

1) Provider is available for consultation to the family 24-7 by phone or in person.

V. Qualifications

Medication Training and Support must be provided within the scope of practice as defined by federal and state law.

- Licensed physician
- Authorized health care professional (AHCP)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a (2) year clinical program.

VI. Billable Unit

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding. Medicaid shall be billed when appropriate.

Billing Code	Title
H0034HW	Medication Training and Support – Individual
H0034 HW HR	Medication Training and Support Family/Couple (Individual Setting), with the Consumer Present
H0034 HW HS	Medication Training and Support Family/Couple (Individual Setting), without the Consumer Present
H0034 HW U1	Medication Training and Support – Group
H0034 HW HR U1	Medication Training and Support Family/Couple (Group Setting), with the Consumer Present
H0034 HW HS U1	Medication Training and Support Family/Couple (Group Setting), without the Consumer Present

Services may be billed in 15 minute increments, partial units are rounded to the nearest quarter using the following guidelines:

- *0 to 7 minutes do not bill 0.00 hour*
- *8 to 22 minutes 1 fifteen minute unit 0.25 hour*
- *23 to 37 minutes 2 fifteen minute units 0.50 hour*
- *38 to 52 minutes 3 fifteen minute units 0.75 hour*
- *53 to 60 minutes 4 fifteen minute units 1.00 hour*

- **Child and Family Team Meeting (CFTM)**: The provider of this service may be requested to participate in the CFTM..The provider may bill DCS for this actual time spent in CFTM.

- **Court:** The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance

includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, signed, and dated DCS/ Probation referral form authorizing services
2) Documentation of regular contact with the referred families/children
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

NOTE: All services must be pre-approved through a referral form from the referring FCM or Probation Officer.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED – PEER RECOVERY SERVICES

I. Service Description

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible adults and children only and will not be provided through DCS funding. (Exception made in payment for Court Appearance and Child and Family Team Meeting. See section VI – Billable Unit) The service standard is not a Medicaid standard and includes services that are not billable to Medicaid. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid.

Peer Recovery Services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

II. Service Delivery

- Peer Recovery Services must be identified in the Individualized Integrated Care Plan (IICP) and correspond to specific treatment goals.
- The consumer is the focus of Peer Recovery Services
- Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the IICP
- Peer Recovery Services are rehabilitative in nature
- Peer Recovery Services must be age appropriate for a consumer age eighteen (18) and under receiving services
- Documentation must support how the service specifically benefits the consumer
- Peer Recovery Services must be face-to-face and include the following components:
    - -Assisting the consumer with developing self-care plans and other formal mentoring activities AIMed at increasing active participation in person-centered planning and delivery of individualized services
    - -Assisting the consumer in the development of psychiatric advanced directives
    - -Supporting day-to-day problem solving related to normalization and reintegration into the community

- Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction

III. Target Population

Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need. In addition, services must be restricted to the following eligibility categories:

1) Consumers age eighteen (18) and older
2) Peer Recovery Service may be provided to consumers ages sixteen (16) and seventeen (17) with an approved prior authorization.
3) Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status.
4) Children and their families which have an IA or the children have the with a status of CHINS, and/or JD/JS;
5) All adopted children and adoptive families.

IV. Goals and Objectives

Goal #1: To become socialized, recover, develop self-advocacy, develop natural supports and maintain community living skills.

V. Qualifications

Peer Recovery Services must be provided by individuals meeting DMHA training and competency standards for CRS (Certified Recovery Specialist). Individuals providing Peer Recovery Services must be under the supervision of a licensed professional or QBHP (Qualified Behavioral Health Professional).

VI. Billable Unit

Peer Recovery Services is included in adult packages only and is limited to 104 units for service package 3, 156 units for service packages 4, 208 units for service package 5, and 260 units for service package 5A. Prior Authorization is required for consumers requiring additional units of this service.

Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding.

Billng Code	Title
H0038 HW	Self help/peer services, per 15 minutes

Exclusions:

- Peer Recovery Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed
- Interventions targeted to groups are not billable as Peer Recovery Services
- Activities that may be billed under Skills Training and Development or Case Management services are not billable as Peer Recovery Services
- Peer Recovery Services are not reimbursable for children under the age of sixteen (16)
- Peer Recovery Services that occur in a group setting are not reimbursable

DCS Funding:

Child and Family Team Meeting (CFTM): MRO provider of this service may be requested to participate in the CFTM. The MRO provider may bill DCS for the actual time spent in CFTM.

Court Appearance: The MRO provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the MRO provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• *0 to 7 minutes*	*do not bill*	*0.00 hour*
• *8 to 22 minutes*	*1 fifteen minute unit*	*0.25 hour*
• *23 to 37 minutes*	*2 fifteen minute units*	*0.50 hour*
• *38 to 52 minutes*	*3 fifteen minute units*	*0.75 hour*
• *53 to 60 minutes*	*4 fifteen minute units*	*1.00 hour*

VII. Case Record Documentation

Necessary case record documentation for service eligibility must include:

5) A completed, dated, signed DCS/Probation referral form authorizing service;
6) Documentation of regular contact with the referred families/children and referring agency;

7) Written reports no less than monthly or more frequently as prescribed by DCS. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
8) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation.

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period. A referral from DCS does not substitute for any authorizations required by the Medicaid program.

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
MED- SUBSTANCE ABUSE ASSESSMENT, TREATMENT & MONITORING

I. Service Description

This service standard applies to families and children involved with the Department of Child Services and/or Probation. Services may be provided for clients of all ages with a substance-related disorder and with minimal manageable medical conditions; minimal withdrawal risk; or emotional, behavioral cognitive conditions that will not prevent the client from benefiting from this level of care. A variety of scientifically based approaches to Substance Use Recovery exists. Recovery prescribed for all clients must be evidenced based. Substance Use Recovery can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination.

Effective Recovery attends to multiple needs of the individual, not just his or her substance use. To be effective, Recovery must address the individual's substance use and any associated medical, social, psychological, vocational, and legal problems.

A face-to-face multi-axial clinical assessment must take place prior to admission to an outpatient program.

II. Service Delivery

A face-to-face clinical interview must take place with each referred individual. The provider must be able to complete the initial assessment within 72 hours of the referral if an emergency exists or sooner if the Family Case Manager suspects the client is in need of detoxification services. For emergency assessments, it is expected that a verbal report will be provided to the referring Family Case Manager within 72 hours and a written report provided within 7 days after the completion of the assessment with the client. Recommendations regarding the client's needs must be provided on each assessment.

The following standardized assessment tools for drug/alcohol use may be administered to accurately determine if further substance use assessment is indicated: Substance Use Subtle Screening Inventory (SASSI), Addiction Severity Index (ASI) Teen Addiction Severity Index (T-ASI), ASI Lite, Addiction Society of Medicine Placement Patient Criteria Revised Version II (ASAM PPII), Drug Use Screening Test (DAST), Substance Use Relapse Assessment (SARA). Other standardized tools may be used to best assess the specific needs of the client.

A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment to include a mental status examination at the time of the initial appointment.

Bio-Psychosocial Assessment must include:
A description of the presenting problem. Clinical Syndromes and/or other conditions that may be a focus of clinical attention. An in-depth drug and alcohol use history with information regarding onset, duration, frequency, and amount of use; substance(s) of use and primary drug of choice. Any associated medical, psychological and social history of the client, associated health, work, family, person, and interpersonal problems; driving record related to drinking or drug use; past participation in treatment programs. The assessment will also include client's attitude toward treatment.

Mental health examination must include: client's mood, affect, memory processes, hallucinations, judgment, insight, and impulse control.

Therapist Recommendations: Following the assessment of each client, the service provider must make a recommendation which includes any necessary treatment as well as the treatment modality and length.

Services must be available to clients who have limited daytime availability. The service provider must identify a plan to engage the client in the process, a plan to work with non-cooperative clients including those who believe they have no problems to address as well as working with special needs clients such as those who are mentally ill or developmentally delayed.

Services are planned and organized with addiction professionals and clinicians providing multiple Recovery service components for the rehabilitation of alcohol and drug use or dependence in a group setting.

An individualized Recovery plan must be developed that considers the client's age, ethnic background, cognitive development and functioning, and clinical issues. Recovery plans should connect substance use and how it affects child safety. Recovery plans shall provide a framework for measuring success and progress. Recovery plans should also include goals and objectives. Goals shall be designed to address the issue(s) identified in the substance use assessment and include an achievable time frame. Objectives shall have an expected result.

All sample collections drug screens will be observed sample collections screens. Minimum of substances tested should include Alcohol, Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Cannabis, Opiates, Methadone, Oxycodone, Propoxyphene, and Methamphetamine and other drugs indicated by clients history. The agency will be expected to provide

reports that state the minimum level necessary to detect the presence of each substance, the level of substance detected, and the chain of custody documentation.

A laboratory participating in DCS/Probation drug testing must comply with all applicable Federal Department of Health and Human Service, and, under these federal requirements, are subsumed Substance Abuse and Mental Health Services Administration (SAMHSA), or College of American Pathology (CAP), or Clinical Laboratory Improvement Act (CLIA) requirements.

Addictions Counseling (Individual Setting) – is designed to be a less intensive alternative to IOT.

1. The client is the focus of the service.
2. Documentation must support how Addiction Counseling benefits the client, including when the client is not present.
3. Addiction Counseling requires face-to-face contact with the client and/or family members or non professional caregivers.
4. Addiction Counseling consists of regularly scheduled sessions as needed.
5. Addiction Counseling may include the following:
- Education on addiction disorders.
- Skills training in communication, anger management, stress management, relapse prevention.

6. Addiction Counseling goals are rehabilitative in nature.
7. Addiction Counseling must be provided in an age appropriate setting for a client less than eighteen (18) years of age receiving services.
8. Addiction Counseling must be individualized.
9. Drug Screens as recommended per level of care or requested by Family Case Manager.
10. Case managements/referrals to available community services.

Exclusions:

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

Addiction Counseling (Group Setting) - is designed to be less intensive alternative to IOT.

1. The consumer is the focus of Addiction Counseling.

2. Documentation must support how Addiction Counseling benefits the consumer, including when services are provided in a group setting and/or the consumer is not present.

3. Addiction Counseling requires face-to-face contact with the consumer and/or family members or non professional caregivers.

4. Addiction Counseling consists of regularly scheduled sessions.

5. Addiction Counseling is intended to be a less intensive alternative to IOT.

6. Addiction Counseling may include the following:

- Education on addiction disorders.
- Skills training in communication, anger management, stress management, relapse prevention.

7. Addiction Counseling must demonstrate progress toward and/or achievement of consumer Recovery goals identified in the IICP.

8. Addiction Counseling goals are rehabilitative in nature.

9. A licensed professional must supervise the program and approve the content and curriculum of the program.

10. Addiction Counseling must be provided in an age appropriate setting for a consumer less than eighteen (18) years of age receiving services.

11. Addiction Counseling must be individualized.

12. Drug Screens as recommended per level of care or requested by Family Case Manager.

13. Case managements/referrals to available community services.

Exclusions:

1. Clients with withdrawal risk or symptoms whose needs cannot be managed at this level of care, or who need detoxification services.
2. Clients at imminent risk of harm to self or others.
3. Addiction Counseling may not be provided for professional caregivers.
4. Addiction Counseling sessions that consists of education services only will not be reimbursed.

Intensive Outpatient Recovery (IOT)

1. Regularly scheduled sessions, within a structured program, that are at least three (3) consecutive hours per day and at least three (3) days per week.

1. IOT includes the following components:
    a. Referral to 12 step programs, peers and other community supports.
    b. Education on Addictions disorders.
    c. Skills training in communication, anger management, stress management and relapse prevention.

d. Individual, group and family therapy (provided by a licensed professional or QBHP Only)

2. IOT must be offered as a distinct service.
3. IOT must be provided in an age appropriate setting for a client age eighteen (18) and under.
4. IOT must be individualized.
5. Access to additional support services (e.g. peer supports, case management, 12-step programs, aftercare/relapse prevention services, integrated Recovery, referral to other community supports) as needed.
6. The client is the focus of the service.
7. Documentation must support how the service benefits the client, including when the service is in a group setting.
8. Services must demonstrate progress toward or achievement of client Recovery goals identified in the IICP.
9. Service goals must be rehabilitative in nature.
10. Up to twenty (20) minutes of break time is allowed during each three consecutive hour session.
11. Drug Screens as recommended per level of care or requested by the Family Case Manager.
12. Referral to available community services is available.

Exclusions:

1. Clients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services
2. Clients at imminent risk of harm to self or others.
3. IOT will not be reimbursed for clients receiving Group Addictions Counseling on the same day.
4. IOT sessions that consist of education services only are not reimbursable.
5. Any service that is less than three hours may not be billed as IOT, but may be billed as Group Addictions Counseling (if provider qualifications and program standards are met)

Specialized Recovery:

Substance use Recovery can also be provided through the use of individual sessions as needed and 1 to 1.5 hours of group weekly or more than once weekly group counseling session based on assessment of individual's needs. Services will be conducted as outlined in the counseling and group counseling section of this service standard, and can include gender specific group counseling to deal specifically with gender issues that may cause barriers to the individual's ability to remain drug free i.e. domestic violence, traumatic events and/or childhood trauma.

Specialized Recovery can also include modalities of brief counseling therapy.

III. Medicaid

It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them, including provider qualifications and any pre-authorization requirements and further, to appropriately bill those services in particular cases where they may be reimbursed by Medicaid. The Services not eligible for MRO or MCO may be billed to DCS.

IV. Target Population

In addition, services must be restricted to the following eligibility categories:

1. Children and families who have substantiated cases of use and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINS status
2. Children and their families which have an IA or the children have the status of CHINS, and/or JD/JS
3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed

V. Goals and Outcome Measures

Goals #1

Recovery plan goals developed from the substance use assessment

Outcome Measure

1) 100% of referred clients will have a Recovery plan developed following the assessment with the Recovery plan provided to the referring worker within 10 days of completion. Recovery goals will be individualized based on assessment with easy to evaluate outcomes.

Goal #2

Regularly modify and update the Recovery plan to reflect client changes and progress.

Outcome Measure:

1) Recovery Plan should identify long and short term goals attainable at 2-, 4-, and 6- month's intervals and measurable by an expected performance or behavior.
2) Vendor shall maintain progress notes that provide details of clients increase in performance and/or behavior that demonstrate growth and/or regression regarding the recovery process and lifestyle changes needed for the individual to remain drug free.

3) Upon successful completion of Recovery the provider shall submit a discharge plan to the referring worker to include client's response to Recovery and aftercare plan.
4) Written reports with no less than monthly or more frequently as prescribed by DCS

Goal #3
Drug screens will be provided to the referring worker in a timely fashion.
Outcome Measures:
1) 100% of positive reports will be reported verbally by phone, voice mail or email within 24 hours of receiving the results of the drug screen. Written reports of the drug screen will be mailed/faxed to the referring worker within 24 hours of receipt of laboratory results.

Goal #4
Provide No-show alert to FCM.
Outcome Measures:
1) 100% of no-show alerts will be provided to referring worker immediately following each no-show.

Goal #5
DCS and client satisfaction with services
Outcome Measures:
1) DCS satisfaction will be rated 4 and above on the Service Satisfaction Report.
2) 80% of the clients who have completed substance use Recovery services will rate the services "satisfactory" or above.

VI. Minimum Qualifications

Medicaid Reimbursed
It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid provider qualifications.

DCS Reimbursed
The program shall be staffed by appropriately credentialed personnel who are trained and competent to complete Substance Use Outpatient Treatment as required by state law.

VII. Billable Units

Medicaid:

Services through the **MCO** may be Outpatient Mental Health Services. Medicaid shall be billed first for eligible services under covered evaluation and management codes, including those in the 90000 range.

MRO
Provision of services will be through Medicaid Rehabilitation Option (MRO) for MRO eligible children only and will not be provided through DCS funding.

Billing Code	**Title**
H2035 HW	Alcohol and/or other drug Recovery program, per hours
H2035 HW HR	Alcohol and/or drug Recovery program, per hour (family/couple, consumer present)
H2035 HW HS	Alcohol and/or drug Recovery program, per hour (family/couple, without consumer present)
H0005 HW	Alcohol and/or other drug services; group counseling by a clinician.
H0005 HW HR	Alcohol and/or drug services; group counseling by a clinician. (family/couple, consumer present)
H0005 HW HS	Alcohol and/or drug services; group counseling by a clinician. (family/couple, without consumer present)
H0015 HW U1	Alcohol and/or other drug services; intensive outpatient (Recovery program that operates at least three(3) hours/day and at least three(3) days/week and is based on an individualized Recovery plan, including assessment, counseling; crisis intervention, and activity therapies or education

DCS funding: Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be billed to DCS per face-to-face hour as outlined below. These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.

1. **The following are billable as Face-to-Face:**

Substance Use Assessment: per hour
A multi-axial system must be used to develop a comprehensive bio-psychosocial assessment to include a mental status examination at the time of the initial appointment. Maximum of 1 hour report writing may be billed per assessment.

Addictions Counseling (Individual & Family): Per hour (Note: Members of the client family are to be defined in consultation with the family and approved by the DCS. This may include persons not legally defined as part of the family.)

- Includes client specific goal directed face-to-face contact with the identified client/family during which services as defined in this Service Standard are performed.
- Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.

Reminder: *Not included is routine report writing and scheduling of appointments, collateral contacts, travel time and no shows. These activities are built into the cost of the face-to-face rate and shall not be billed separately.*

2. **Counseling Group**

Services include group goal directed work with clients. To be billed per person per hour.

Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:

• *0 to 7 minutes*	*do not bill*	*0.00 hour*
• *8 to 22 minutes*	*1 fifteen minute unit*	*0.25 hour*
• *23 to 37 minutes*	*2 fifteen minute units*	*0.50 hour*
• *38 to 52 minutes*	*3 fifteen minute units*	*0.75 hour*
• *53 to 60 minutes*	*4 fifteen minute units*	*1.00 hour*

3. Court Appearance

The provider of this service may be requested to testify in court. A Court Appearance is defined as appearing for a court hearing after receiving a request (either verbal or written) by DCS to appear in court, and can be billed per appearance. Therefore, if the provider appeared in court two different days, they could bill for 2 court appearances. Maximum of 1 court appearance per day. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

4. Drug Screens

Actual cost of the screens.

5. Translation or sign language

Services include translation for families who are non-English language speakers or hearing impaired and must be provided by a non-family member of the client. Dollar for dollar amount.

VII. Case Record Documentation

Case record documentation for service eligibility must include:

1) A completed, dated, signed DCS/Probation referral form authorizing service;
2) Documentation of regular contact with the referred families/children and referring agency;
3) Written reports no less than monthly or more frequently as prescribed by DCS/Probation. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
4) Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for documents given to DCS/Probation

VIII. Service Access

All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation, an approved DCS referral will still be required. Referrals are valid for a maximum of six (6) months

unless otherwise specified by the DCS/Probation. Providers must initiate a re-authorization for services to continue beyond the approved period.

IX. Adherence to the DCS Practice Model

Services must be provided according to the Indiana Practice Model. Providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect. Providers will use the skills of engaging, assessing, planning and intervening to partner with families and the community to better outcomes for children.